STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING 00 B. WING	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 30, 31 and April 1, 2, 3 and 4, 2025 Facility number: 000051 Provider number: 155121 AIM number: 100275490 Census Bed Type: SNF/NF: 108 SNF: 2 Total: 110 Census Payor Type: Medicare: 2 Medicaid: 97 Other: 11 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 10, 2025.	F 0000	Rosewalk Village of Lafayette respectfully requests desk review for these deficiencies.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on interview and record review, the facility failed to ensure a preadmission screening and resident review (PASARR) was completed when an antipsychotic medication and mental health diagnosis was added for 1 of 1 resident reviewed for PASARR. (Resident 97) Findings include:	F 0644	F644 Coordination of PASARR and Assessments It is the practice of this facility to ensure accurate PASARR assessments. What corrective action(s) will be accomplished for those residents found to have been affected by the	05/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Anderson	Executive Director	04/23/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The clinical record for Resident 97 was reviewed on 3/31/25 at 11:48 a.m. The diagnoses included, but were not limited to, anxiety disorder and depressive disorder. A PASARR, dated 11/20/24, indicated Resident 97 did not have any mental health diagnoses or mental health medications. A physician's order, dated 12/17/24, indicated to administer sertraline (an antidepressant medication) 50 milligram (mg) once a day. A physician's order, dated 2/17/25, indicated to administer clonazepam (an antianxiety medication) 0.25 mg at bedtime. During an interview, on 4/3/25 at 3:34 p.m., the Executive Director (ED) indicated Resident 97 did not have a new PASARR level I completed when the new medications or diagnoses were added. During an interview, on 4/4/25 at 12:26 p.m., the Social Service Director indicated the resident did not have a new PASARR level I completed when the psychotropic medications and mental health diagnoses were added. A new PASARR should have been completed. A current facility policy, titled "PASARR Policy," dated 11/17 and received from the Executive Director on 4/3/25 at 3:36 p.m., indicated "...It is the policy of this facility to ensure that...PASARR assessments are updated with significant changes in mental or physical status...." A current facility policy, titled "Psychotropic Management," dated 9/24 and received from the Executive Director on 4/4/25 at 11:12 a.m.,		deficient practice: Resident 97 PASARR assessments has been resubmitted to include updated diagnoses. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this finding. All PASARR assessments will be audited to ensure accurate coding of diagnoses. Any inaccurate coding identified will be modified and resubmitted to ensure accuracy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ED/designee will in-service the IDT on accurate coding of PASARR on or before 5/7/25. IDT will review each resident's PASARR with the addition of any new diagnosis. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). Social Service Director/designee will complete the QA tool labeled "PASARR" weekly for 4 weeks,	

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	indicated "...It is the policy of this facility to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being with person centered intervention and assessment...These drugs included, but are not limited to...Anti-psychotic; Anti-depressant; Anti-anxiety...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 5/7/25	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview and record review, the facility failed to ensure a dependent resident was provided incontinence care in a timely manner for 1 of 1 dependent resident reviewed for activities of daily living (ADL) care. (Resident 39) Findings include: During an observation, on 3/30/25 at 1:03 p.m., Resident 39 was in the dining room sitting in a wheelchair. The resident was leaning to his left side and was sliding down in his seat. A strong bowel movement and urine odor came from the resident. The resident's sweatpants on the right side were pulled down and the resident had his hand in his pants. There was bowel movement all over his right hand. Certified Nursing Assistant (CNA) 2 entered the dining room, unlocked the wheelchair brakes, and took the resident to his room. During an interview, on 3/30/25 at 1:05 p.m., CNA 2 indicated Resident 39 was last checked/changed at 10:00 a.m. and residents were to be checked and	F 0677	F677 ADL Care Provided for Dependent Residents It is the practice of this facility to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 39 received immediate incontinence care from staff. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who are dependent for ADL care have the potential to be affected by this finding. All dependent residents will be reviewed to ensure a toileting care plan is in place and observed that	05/07/2025

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	changed every 2 hours. The clinical record for Resident 39 was reviewed on 4/2/25 at 10:48 a.m. The diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, bipolar disorder, anxiety disorder, schizophrenia, psychotic disorder with delusions, conduct disorder, and cognitive communication deficit. A care plan, dated 2/21/23, indicated the resident required assistance with morning and evening care, nutrition, hydration, and elimination. A care plan, dated 2/22/23, indicated the resident required assistance with toileting due to incontinence. Interventions included, but were not limited to, assist with incontinence care as needed, check every 2 hours for incontinence, and document any abnormal findings and notify the physician. A care plan, dated 2/22/23, indicated the resident required assistance with activities of daily living which included bed mobility, transfers, eating, and toileting. Interventions included, but were not limited to, assistance with one staff for toileting and incontinent care. An annual Minimum Data Set (MDS) assessment, dated 12/12/24, indicated the resident was severely cognitively impaired. A quarterly MDS assessment, dated 4/8/24, indicated Resident 39 was dependent on staff for toileting hygiene, showers and baths, and personal hygiene. During an interview, on 3/30/25 at 1:13 p.m., CNA 3 indicated residents should be checked every 2		the care plan in place is followed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DNS/designee will in-service all Nursing staff on incontinence care of a dependent resident on or before 5/7/25. DNS/designee will observe each dependent resident daily to ensure incontinent care is provided as care planned. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). DNS/designee will complete the QA tool labeled “Incontinence Care” weekly for 4 weeks, monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 5/7/25	

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	hours and changed if needed. Resident 39's brief had a very strong odor of urine and bowel movement. During an interview, on 4/3/25 at 4:03 p.m., Resident 39's family member indicated when he would visit the resident at mealtimes, the resident would have dried bowel movement on his hands. The staff did not wipe off the resident's hands before meals and he would eat with the dried bowel movement on them. The resident had been observed multiple times with dried bowel movement on his hands during meals. During an interview, on 4/4/25 at 10:41 a.m., CNA 4 indicated when residents were in the dining room, she would check and change the residents every hour. If a resident could not communicate, CNA 4 would take the resident to their room to check and change them every 2 hours. A Certified Nursing Assistant job description, dated 10/2014, indicated the CNA should maintain a homelike environment for the residents, protect and promote resident rights, and assist the person to maintain independence and control to the greatest extent possible. Promptly assist residents to the bathroom according to their toileting schedule or promptly bring a clean bedpan or urinal. Open, remove clothing in preparation, clean the resident if the resident was unable to clean self, adjust clothing, clean resident's and own hands. Change position of bedfast residents at least every two hours. A current facility policy, titled "Bowel and Bladder Program," dated 5/2019 and received by the Executive Director on 3/31/25 at 3:31 p.m., indicated "...If a resident is totally incontinent and unable to be placed on a toilet or bedpan, resident			

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	should be checked and changed every two hours...." 3.1-38(a)(2)(c) 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure insulin doses were not administered when the blood sugar readings were below the physician's ordered hold parameter for 1 of 2 residents reviewed for quality of care. (Resident 12) The deficient practice was corrected on 3/28/25, prior to the start of the survey, and therefore was past noncompliance. Findings include: The clinical record for Resident 12 was reviewed on 4/1/25 at 11:50 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, diabetic nephropathy, and chronic kidney disease. A physician's order, dated 11/21/24, indicated to give 35 units of Fiasp FlexTouch U-100 Insulin (a fast-acting insulin) three times a day with special instructions to hold for a blood sugar below 130. The Medication Administration Record (MAR), dated 12/1/24 through 12/31/24, indicated 35 units of Fiasp FlexTouch U-100 Insulin were administered on the following dates with a blood sugar below 130: On 12/1/24, with a blood sugar of 97. On 12/2/24, with a blood sugar of 112, 112, and 109. On 12/3/24, with a blood sugar of 116.	F 0684	Past noncompliance: no plan of correction required.	05/07/2025

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	On 12/4/24, with a blood sugar of 111. On 12/8/24, with a blood sugar of 121. On 12/9/24, with a blood sugar of 87. On 12/14/24, with a blood sugar of 91. On 12/17/24, with a blood sugar of 111. On 12/20/24, with a blood sugar of 117. On 12/21/24, with a blood sugar of 126. On 12/27/24, with a blood sugar of 126. On 12/28/24, with a blood sugar of 83. On 12/29/24, with a blood sugar of 96. On 12/30/24, with a blood sugar of 107 and 116. The MAR, dated 1/1/25 through 1/31/25, indicated 35 units of Fiasp FlexTouch U-100 Insulin were administered on the following dates with a blood sugar below 130: On 1/6/25, with a blood sugar of 98. On 1/10/25, with a blood sugar of 124. On 1/12/25, with a blood sugar of 120. On 1/14/25, with a blood sugar of 116. On 1/15/25, with a blood sugar of 126. On 1/17/25, with a blood sugar of 110. On 1/19/25, with a blood sugar of 129. On 1/26/25, with a blood sugar of 122. The MAR, dated 2/1/25 through 2/28/25, indicated 35 units of Fiasp FlexTouch U-100 Insulin were administered on the following dates with a blood sugar below 130: On 2/5/25, with a blood sugar of 128. On 2/11/25, with a blood sugar of 126. On 2/12/25, with a blood sugar of 129. On 2/19/25, with a blood sugar of 124. On 2/21/25, with a blood sugar of 115. On 2/23/25, with a blood sugar of 128. During an interview, on 4/3/25 at 11:17 a.m., LPN 6 indicated when an insulin dose was held based on the physician's hold parameter, the nurse's initials on the MAR were in parenthesis or it would have			

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	been marked as zero (0) units given. During an interview, on 4/3/25 at 11:20 a.m., RN 7 indicated a residents' insulin dose should be held if the blood sugar was below the ordered hold parameter. During an interview, on 4/4/25 at 11:45 a.m., the Director of Nursing (DON) indicated the facility had noticed medications were administered against the ordered hold parameters. Staff education was completed, a quality improvement plan was formed, and monitored throughout March. Their quality improvement plan was completed 3/28/25. During an interview, on 4/3/25 at 2:15 p.m., the DON indicated the facility did not have a specific insulin administration policy or a policy related to following a physician's ordered hold parameter. A current facility policy, titled "Medication Administration (Medication Pass Procedure)," dated 7/2023 and received from the DON on 4/3/25 at 2:15 p.m., indicated "...Vital signs were obtained, if necessary...Perform the 5 rights of medication...Right Dose...." The deficient practice was corrected by 3/28/25, after the facility implemented a systemic plan which included audits and conducting staff education on following the physician's ordered hold parameters with all nursing staff. 3.1-37(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record	F 0812	F812 Food Procurement,	05/07/2025

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	review, the facility failed to ensure employee food and drinks were not stored in the kitchen, cardboard boxes were off the floor, and expired food was discarded. This deficient practice had the potential to affect 110 of 110 residents who received food from the kitchen. Findings include: During the kitchen observation, on 3/30/25 at 10:20 a.m., with the Executive Director (ED), the following were observed: a. The reach-in refrigerator contained two brown plastic grocery sacks containing employee lunches. b. The walk-in freezer had one large cardboard box containing a bag of frozen blueberries and one large cardboard box with two boxes stacked on top. The cardboard boxes were stored on the floor. c. The food preparation station had two half empty clear plastic waters bottles stored on the shelf in the food area. d. The food preparation refrigerator had a large clear container of diced ham with a use-by date of 3/27/25. e. The food preparation station had four empty cardboard boxes on the floor under the food preparation sink. During an interview, on 3/30/25 at 10:28 a.m., the ED indicated the employees were not supposed to store their lunches in the refrigerator. During an interview, on 3/30/25 at 10:48 a.m., the ED indicated food, or cardboard boxes should not have been stored on the floor. During an interview, on 3/30/25 at 11:15 p.m., Cook 7 indicated staff should not have had their drinks		Storage/Prepare/Serve-Sanitary It is the practice of this facility to ensure food is prepared and stored in compliance with currently accepted professional principles. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: • Employee lunches were immediately removed from reach-in refrigerator • Boxes on the floor were immediately removed from walk-in freezer • The clear plastic water bottles were immediately removed from food preparation station • The diced ham was immediately discarded from the walk-in refrigerator • The empty boxes were immediately removed from the floor under the preparation sink How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this finding. A kitchen audit will be completed by ED/designee for culinary sanitation and any findings will be immediately corrected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	

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	or food in the kitchen. During an interview, on 3/30/25 at 12:19 p.m., the Dietary Manager (DM) indicated the cardboard boxes should not have been on the floor and nothing should have been stored on the floor. A current facility policy, titled "Food Storage," dated as revised 5/23 and received from the ED on 3/31/25 at 3:31 p.m., indicated "...Sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is stored at an appropriate temperature and by methods designed to prevent contamination...Food is stored a minimum of 6" above the floor and 18" below the sprinkler heads on clean racks or other clean surfaces and protected from contamination...Leftover prepared foods and processed meats such as lunchmeat, are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared, and marked to indicate the date by which the food shall be consumed or discarded...." 3.1-21(i)(3)		The ED/designee will in-service culinary staff on food handling, food storage and labeling on or before 5/7/25. ED/designee will conduct daily am check list to ensure food handling and food storage is performed correctly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Culinary Sanitation” weekly for 4 weeks, monthly for 4 months and quarterly thereafter for at least 2 quarters. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: Compliance Date: 5/7/25	